INSURANCE

Budget Summary

Fund	2018-19 Base Year Doubled	2019-21 Governor	2019-21 Jt. Finance	2019-21 Legislature	2019-21 Act 9	Act 9 Change Over Base Year Doubled Amount	Act 9 Change Over Base Year Doubled Percent
GPR	$0	$72,273,700	$72,273,700	$72,273,700	$72,273,700	$72,273,700	N.A.
FED	1,228,800	127,726,300	127,726,300	127,726,300	127,726,300	126,497,500	N.A.
PR	39,293,200	40,915,200	39,480,400	39,480,400	39,480,400	187,200	0.5%
SEG	183,551,800	122,426,700	122,426,700	122,426,700	122,426,700	- 61,125,100	- 33.3
TOTAL	$224,073,800	$363,341,900	$361,907,100	$361,907,100	$361,907,100	$137,833,300	61.5%

FTE Position Summary

Fund	2018-19 Base	2020-21 Governor	2020-21 Jt. Finance	2020-21 Legislature	2020-21 Act 9	Act 9 Change Over 2018-19 Base
FED	5.10	0.00	0.00	0.00	0.00	- 5.10
PR	124.15	131.25	124.15	124.15	124.15	0.00
SEG	11.75	10.68	10.68	10.68	10.68	- 1.07
TOTAL	141.00	141.93	134.83	134.83	134.83	- 6.17

Budget Change Items

1. STANDARD BUDGET ADJUSTMENTS

FED	- $146,200
PR	168,700
SEG	56,600
Total	$79,100

Governor/Legislature: Provide $23,300 (-$73,100 FED, $68,600 PR and $27,800 SEG) in 2019-20 and $55,800 (-$73,100 FED, $100,100 PR, and $28,800 SEG) in 2020-21 to reflect the following standard budget adjustments: (a) -$242,900 PR annually for turnover reduction; (b) -$73,100 FED, $526,300 PR, and $34,600 SEG annually for full funding of continuing position salaries and fringe benefits; and (c) -$214,800 PR and -$6,800 SEG in 2019-20 and -$183,300 PR and -$5,800 SEG in 2020-21 for full funding of lease and directed move costs.

2. WISCONSIN HEALTHCARE STABILITY PLAN [LFB Paper 440]

GPR	$72,273,700
FED	127,726,300
Total	$200,000,000

Governor/Legislature: Provide $72,273,700 GPR and $127,726,300 FED in 2020-21 to fund estimated reinsurance payments for plan year 2019 under the Wisconsin healthcare stability plan (WHSP). WHSP was authorized under 2017 Wisconsin Act 138 and implemented under the terms of a waiver agreement, pursuant to Section 1332 of the federal Affordable Care Act. WHSP is a state-operated reinsurance program, supported with state and federal funding, that is intended to reduce premiums paid by individuals who purchase health insurance in the individual market. Reinsurance payments reimburse insurers for a portion of the total annual claims for individuals with high costs. For 2019, the program will pay 50% of the total annual claims between $50,000 and $250,000.

Act 138 authorized OCI to expend up to $200 million (all funds) in each year, beginning for plans sold for coverage in 2019, to make payments to health insurers to subsidize the cost of individual health policies purchased by Wisconsin residents. The act created two appropriations to fund these payments. First, a federal appropriation enables OCI to expend all moneys the agency receives under the terms of the waiver agreement, generated by federal savings resulting from reduced costs of premium tax credits. Second, a sum-sufficient GPR appropriation is intended to fund the difference between available federal funds and the total subsidies available in each year. On November 30, 2018, the federal Department of Health and Human Services notified the state that the state's federal pass through funding for the 2019 plan year is estimated at $127,726,300. This item reflects this estimate and an estimate of the GPR funding that would be needed to make up the difference between the $200 million total and the federal pass through funding. OCI expects to make plan year 2019 reinsurance payments in July of 2020, based on timelines established for the program by Act 138.

3. PHASE OUT LOCAL GOVERNMENT PROPERTY INSURANCE FUND

	Funding	Positions
SEG	- $61,181,700	- 1.07

Governor/Legislature: Reduce funding by $30,590,800 in 2019-20 and $30,590,900 in 2020-21 and delete 1.07 positions, beginning in 2019-20, to reflect the phase out of the local government property insurance fund (LGPIF). The LGPIF is a property insurance program for local governments. The 2017-19 biennial budget act included a provision that prohibits OCI from issuing or renewing policies with an end date past December 31, 2018. All claims must be submitted by July 1, 2019. This item has two components. First, the bill would reduce the appropriation for paying claims by $29,160,200 annually, leaving $500,000 annually in remaining expenditure authority for any remaining claims. Second, the bill would reduce funding in the program's appropriation for administrative costs by $1,430,600 in 2019-20 and $1,430,700 in 2020-21, which in combination with standard budget adjustments, would eliminate all funding for the administration of the program.

4. NONRESIDENT INSURANCE APPOINTMENT FEE [LFB Paper 441]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
PR-REV	$6,150,000	- $6,150,000	$0
GPR-REV	6,150,000	- 6,150,000	0

Governor: Increase the annual fee for nonresident insurance appointments by $10, from $30 to $40, effective January 1, 2020. Increase estimated PR revenue collected by OCI by $2,050,000 in 2019-20 and $4,100,000 in 2020-21 to reflect this increase. Under current law, in each year, all program revenues collected by OCI that are credited to the agency's general program operations appropriation that exceed 10% of that fiscal year's expenditures lapse to the general fund. Under this provision, OCI currently deposits approximately $20 million annually to the general fund. Since this item would increase PR revenue collected by OCI, it would increase general fund revenues by the amounts of the program revenue increases.

Under current law, insurers are required to appoint intermediaries (generally, licensed insurance agents) who solicit, negotiate, or place insurance or annuities on behalf of the insurer. Insurers are required to report to OCI all appointments, including renewals of appointments, and all terminations of appointments of insurance agents that do business in Wisconsin, and pay a fee for each resident and nonresident appointment. The 2017-19 budget act reduced the nonresident appointment fee by $10, from $40 to $30, effective on January 1, 2019. The proposed fee increase in this item would restore the nonresident appointment fee to the amount levied prior to that reduction. The annual appointment fee for agents who are Wisconsin residents is $16, and would not be affected by this item.

Joint Finance/Legislature: Delete provision.

5. HEALTHCARE OUTREACH POSITIONS [LFB Paper 442]

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
PR	$1,082,600	5.10	- $1,082,600	- 5.10	$0	0.00

Governor: Provide $541,300 annually to fund 5.1 positions, beginning in 2019-20, to provide health insurance education and outreach activities, including assisting individuals with enrolling in the health insurance exchange. Of this funding, $333,600 annually would be budgeted for position salary and fringe benefits, and $207,700 annually would be budgeted for supplies and services associated with these positions, including travel and other program costs.

Joint Finance/Legislature: Delete the 5.1 positions and transfer $541,300 annually to the Joint Finance Committee's program supplements appropriation, which would enable OCI to submit a request to the Committee for release of the expenditure authority to make grants for health insurance education and outreach.

6. RATE REVIEWS -- DELETE EXPIRED FEDERAL FUNDING AND POSITION AUTHORITY

	Funding	Positions
FED	- $1,082,600	- 5.10

Governor/Legislature: Reduce funding by $541,300 annually and delete 5.10 positions, beginning in 2019-20, to reflect the elimination (in combination with standard budget adjustments) of funding and position authority that had previously been used for health insurance rate review. The rate review process was supported by one-time federal grants that have expired. OCI indicates that rate review functions will be supported from current staff supported by the agency's general program operations PR appropriation during the 2019-21 biennium.

7. PRESCRIPTION DRUG PRICING AND COST REPORTING

	Governor (Chg. to Base)		Jt. Finance/Leg. (Chg. to Gov)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
PR	$352,200	2.00	- $352,200	- 2.00	0.00	000

Governor: Provide $176,100 annually to support 2.0 positions, beginning in 2019-20, to administer new OCI program responsibilities related to the submission of reports by prescription drug manufacturers, pharmacy benefit managers, health insurers, and certain hospitals regarding prescription drug costs and pricing. The statutory provisions in the bill regarding prescription drug pricing and costs are described below.

Provisions Affecting Prescription Drug Manufacturers. Require a prescription drug manufacturer to notify the Insurance Commissioner (hereafter, OCI) if it is increasing the wholesale acquisition cost of a brand-name drug on the market in Wisconsin by more than ten percent or by more than $10,000 during any 12-month period or if it intends to introduce to market in Wisconsin a brand-name drug that has an annual wholesale acquisition cost of $30,000 or more. In addition, require a manufacturer to notify OCI if it is increasing the wholesale acquisition cost of a generic drug by more than 25 percent or by more than $300 during any 12-month period or if it intends to introduce to market a generic drug that has an annual wholesale acquisition cost of $3,000 or more. Define "wholesale acquisition cost" as the most recently reported manufacturer list or catalog price for a brand-name drug or a generic drug available to wholesalers or direct purchasers in the United States, before application of discounts, rebates, or reductions in price.

Require each manufacturer to provide these notices in writing at least 30 days before the planned effective date of the cost increase or drug introduction with a justification that includes all documents and research related to the manufacturer's selection of the cost increase or introduction price and a description of life cycle management, market competition and context, and estimated value or cost-effectiveness of the product.

Require each manufacturer, by March 1 annually, to report to OCI the following: (a) the value of price concessions, expressed as a percentage of the wholesale acquisition cost, provided to each pharmacy benefit manager for each drug sold in Wisconsin; and (b) a description of each

manufacturer sponsored patient assistance program in effect during the previous year that includes all of the following: (i) the terms of the programs; (ii) the number of prescriptions provided to Wisconsin residents under the program; and (iii) the total market value of assistance provided to Wisconsin residents under the program. Define a "manufacturer-sponsored assistance program" as a program offered by a manufacturer or an intermediary under contract with a manufacturer through which a brand-name drug or a generic drug is provided to a patient at no charge or at a discount. Specify that the term "manufacturer" does not include an entity that is engaged only in the dispensing of a brand-name drug or a generic drug.

Provisions Affecting Pharmacy Benefit Managers. Prohibit any person from performing any activities of a pharmacy benefit manager (PBM) in Wisconsin without first registering with OCI. Require OCI to establish a registration procedure for PBMs and authorize OCI to promulgate any rules necessary to implement these registration procedures. PBMs are defined, under current law, as an entity doing business in Wisconsin that contracts to administer or manage prescription drug benefits on behalf of any insurer or other entity that provides prescription drug benefits to state residents.

Require each PBM, by March 1 annually, to report to OCI the amount it received from manufacturers as drug rebates and the value of price concessions, expressed as a percentage of the wholesale acquisition cost, provided by manufacturers for each drug.

Provisions Affecting Hospitals. Require hospitals that participate in the federal 340B drug discount program, by March 1 annually, to report to OCI the per unit margin for each drug covered under the 340B program that was dispensed in the previous year multiplied by the number of units dispensed at that margin and how the margin revenue was used. Define "margin" to mean the difference between the net cost of each drug and the net payment by the hospital. For the purposes of this provision, the net payment is the amount paid after all discounts and rebates have been applied. The 340B program requires drug manufacturers to provide drugs to certain entities, including certain nonprofit hospitals, at a discounted price.

Provisions Affecting Health Insurers. Require each health insurer, at the time the insurer files a premium rate request with OCI for review, to also submit a report that identifies the 25 prescription drugs that are the highest cost to the insurer and the 25 prescription drugs that have the highest cost increases over the 12 months before the submission of the report.

Require OCI to ensure that health insurers that cover prescription drugs do not restrict pharmacies or pharmacists that dispense drugs or biological products from informing, or penalize pharmacies or pharmacists for informing, an insured under a policy of a difference between the negotiated price of, or copayment or coinsurance for, the drug or biological product under the policy and the price the insured would pay for the drug or biological product if the insured obtained the drug or biological product without using any health insurance coverage.

OCI Responsibilities. Require OCI to publicly post manufacturer price justification documents and hospital documentation of how each hospital spends the 340B drug margin revenue. Require OCI to keep any trade secret or proprietary information confidential.

Require OCI to analyze data collected under these provisions and publish annually a report

on emerging trends in prescription prices and price increases, and to annually conduct a public hearing based on this analysis. Specify that the report must include: (a) an analysis of manufacturer prices and price increases; (b) an analysis of hospital-specific margins under the 340B program and how that revenue is spent or allocated on a hospital-specific basis; and (c) an analysis of how pharmacy benefit manager discounts and net costs compare to retail prices paid by patients.

Require OCI to conduct a statistically-valid survey of pharmacies in Wisconsin regarding whether the pharmacy agreed to not disclose that customer drug benefit cost sharing exceeds the cost of the dispensed drug.

Joint Finance/Legislature: Delete provision.

8. BOALTC HELPLINE FUNDING TRANSFER

PR	$18,500

Governor/Legislature: Provide $8,800 in 2019-20 and $9,700 in 2020-21 to reflect a reestimate of the amount of insurance fee revenue that will be needed to fund telephone counseling services provided by the Board on Aging and Long-Term Care (BOALTC) for individuals seeking information on Medicare supplemental insurance policies ("Medigap" policies), Medicare Part D policies (policies that cover prescription drugs), and SeniorCare.

The BOALTC Helpline provides free one-on-one insurance counseling services to state residents over the age of 60. The Helpline is supported from two sources -- federal funds the state receives under the state health insurance assistance program (SHIP) and state insurance fee revenue budgeted as part of OCI's general program operations appropriation that OCI transfers to BOALTC.

9. HEALTH INSURANCE ISSUANCE AND COVERAGE REQUIREMENTS

Governor: Incorporate provisions of 2019 Senate Bill 37 into the bill. These provisions make various modifications to current law health insurance and health benefit plan regulations, as they relate to issuance and renewal of policies, premiums, cost sharing, and coverage requirements, as described below.

Guaranteed Issue and Renewal of Policies. Require every individual health benefit plan and every group health benefit plan to accept every individual and every employer, as applicable, that applies for coverage, regardless of sexual orientation, gender identity, or whether or not any employee or individual has a preexisting condition. Specify that a health benefit plan may restrict enrollment in coverage to open or special enrollment periods. Require the Insurance Commissioner (OCI) to establish a statewide open enrollment period of no shorter than 30 days for every individual health benefit plan to allow individuals, including individuals who do not have coverage, to enroll in coverage.

Prohibit Preexisting Condition Exclusions. Prohibit an insurer that offers a group health benefit plan or an individual insurance policy from imposing a preexisting condition exclusion (the denial or reduction of a claim related to a condition that existed prior to the effective date of

coverage). Modify related statutory definitions and provisions that place limits on preexisting condition exclusions and to reflect the change to a general prohibition against the practice.

Prohibit Discrimination Based on Health Status -- Enrollment, Premiums and Cost Sharing. Prohibit an individual health benefit plan or a government self-insured plan from establishing rules for the eligibility of any individual to enroll, or the continued eligibility to remain enrolled in a plan based on any of the following: (a) health status; (b) medical condition, including both physical and mental illnesses; (c) claims experience; (d) receipt of health care; (e) medical history; (f) genetic information; (g) evidence of insurability, including conditions arising out of acts of domestic violence; or (h) disability.

Prohibit an insurer offering an individual health benefit plan or a self-insured plan from requiring any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status-related factor listed above, with respect to the individual or a dependent of the individual, a premium or contribution or a deductible, copayment, or coinsurance amount that is greater than that required for a similarly situated individual enrolled under the plan.

Specify that these restrictions do not prevent an insurer from offering an individual health benefit plan or a self-insured health plan from establishing premium discounts or rebates or modifying otherwise applicable cost sharing in return for adherence to programs of health promotion and disease prevention.

Modify a current law provision, applicable to group health benefit plans, from charging different premiums to similarly-situated individuals based on any health status-related factor, to also prohibit charging a different deductible, copayment, or coinsurance amount to similarly-situated individuals based on health status.

Restrictions on Premium Rate Variation. Specify that a health benefit plan offered on the individual or small employer market (between two and 50 employees) or a self-insured health plan may vary premium rates for a specific plan based only on the following considerations: (a) whether the policy or plan covers an individual or a family; (b) the rating area in the state, as established by OCI; (c) age, except that the rate may not vary by more than three-to-one for adults over the age groups and the age bands shall be consistent with recommendations of the National Association of Insurance Commissioners; and (d) tobacco use, except that the rate may not vary by more than 1.5-to-one.

Prohibit Annual and Lifetime Limits. Prohibit an individual or group health benefit plan or a government self-insured health plan from establishing lifetime or annual limits on the dollar value of benefits for an enroll or a dependent of an enrollee under the plan.

Applicability of Provisions to Short-Term, Limited Duration Plans. Specify that the provisions summarized above related to guaranteed issue, preexisting condition exclusions, discrimination based on health status, restrictions on premiums, and annual and lifetime limits also apply to short-term, limited-duration health insurance policies. Define a short-term, limited-duration health insurance policy as health coverage that is provided under contract with an insurer, has an expiration date specified in the contract that is less than 12 months after the original

effective date of the contract, and, taking into account renewals or extensions, has a duration of no longer than 36 months in total.

Essential Health Benefits. Require every health insurance policy (except for specified restricted-benefit policies) and every government self-insured health plan to provide coverage for essential health benefits, as determined by OCI by rule, on a date specified by OCI by rule. Require OCI, in determining the essential health benefits for which coverage is required, to included benefits, items, and services in, at least, all of the following categories: (a) ambulatory patient services; (b) emergency services; (c) hospitalization; (d) maternity and newborn care; (e) mental health and substance use disorder services, including behavioral health treatment; (f) prescription drugs; (g) rehabilitative and habilitative services and devices; (h) laboratory services; (i) preventive and wellness services and chronic disease management; and (j) pediatric services, including oral and vision care.

Require OCI to do the following with respect to essential health benefits: (a) conduct a survey of employer-sponsored coverage to determine benefits typically covered by employers and ensure that the scope of essential health benefits for which coverage is required is equal to the scope of benefits covered under a typical insurance policy offered by an employer to its employees; (b) ensure that essential health benefits reflect a balance among the essential health benefit categories such that benefits are not unduly weighted toward one category; (c) ensure that essential health benefit coverage is provided with no or limited cost-sharing requirements; (d) require that insurance policies and self-insured health plans do not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life; (e) establish essential health benefits in a way that takes into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; (f) ensure that essential health benefits are not subject to a coverage denial based on an insured's or plan participant's age, expected length of life, present or predicted disability, degree of dependency on medical care, or quality of life; (g) require that insurance policies and government self-insured health plans cover emergency department services that are essential health benefits without imposing any requirement to obtain prior authorization for those services and without limiting coverage for services provided by an emergency services provider that is not in the provider network of a policy or plan in a way that is more restrictive than requirements or limitations that apply to emergency services provided by a provider that is in the provider network of the policy or plan; (h) require an insurance policy or government self-insured health plan to apply to emergency department services that are essential health benefits provided by an emergency department provider that is not in the provider network of the policy or plan the same copayment amount or coinsurance rate that applies if those services are provided by a provider that is in the provider network of the policy or plan; and (i) periodically update, by rule, the essential health benefits to address any gaps in access to coverage.

Specify that if an essential health benefit is also subject to other coverage mandates specified in state statute and the coverage requirements are not identical, the insurance policy or government self-insured health plan shall provide coverage under whichever provision provides the insured or plan participant with more comprehensive coverage of the medical condition, item, or service. Specify that the essential health benefit provisions or rules promulgated under these provisions do

not prohibit an insurance policy or a government self-insured health plan from providing benefits in excess of the essential health benefit coverage.

Coverage of Preventive Services and other Mandatory Coverage Requirements. Require every health insurance policy (except for specified restricted-benefit policies) and every government self-insured health plan to provide coverage for the preventive services listed below. These preventive services are generally from the list of services given an "A" or "B" rating by the U.S. Preventive Services Task Force. Under federal regulations developed to implement provisions of the Affordable Care Act, these services must be covered with no cost sharing by insurance policies and health plans.

- Mammography.

- Genetic breast cancer screening and counseling and preventive medication for adult women at high risk for breast cancer.

- Papanicolaou test for cancer screening for women 21 years of age or older with an intact cervix.

- Human papillomavirus testing for women who have attained the age of 30 years but have not attained the age of 66 years.

- Colorectal cancer screening.

- Annual tomography for lung cancer screening for adults who have attained the age of 55 years but have not attained the age of 80 years and who have health histories demonstrating a risk for lung cancer.

- Skin cancer screening for individuals who have attained the age of ten years but have not attained the age of 22 years.

- Counseling for skin cancer prevention for adults who have attained the age of 18 years but have not attained the age of 25 years.

- Abdominal aortic aneurysm screening for men who have attained the age of 65 years but have not attained the age of 75 years and who have ever smoked.

- Hypertension screening for adults and blood pressure testing for adults, for children under the age of three years who are at high risk for hypertension, and for children three years of age or older.

- Lipid disorder screening for minors two years of age or older, adults 20 years of age or older at high risk for lipid disorders, and all men 35 years of age or older.

- Aspirin therapy for cardiovascular health for adults who have attained the age of 55 years but have not attained the age of 80 years and for men who have attained the age of 45 years but have not attained the age of 55 years.

- Behavioral counseling for cardiovascular health for adults who are overweight or

obese and who have risk factors for cardiovascular disease.

- Type II diabetes screening for adults with elevated blood pressure.

- Depression screening for minors 11 years of age or older and for adults when follow-up supports are available.

- Hepatitis B screening for minors at high risk for infection and adults at high risk for infection.

- Hepatitis C screening for adults at high risk for infection and one-time hepatitis C screening for adults born in any year from 1945 to 1965.

- Obesity screening and management for all minors and adults with a body mass index indicating obesity, counseling and behavioral interventions for obese minors who are 6 years of age or older, and referral for intervention for obesity for adults with a body mass index of 30 kilograms per square meter or higher.

- Osteoporosis screening for all women 65 years of age or older and for women at high risk for osteoporosis under the age of 65 years.

- Immunizations.

- Anemia screening for individuals six months of age or older and iron supplements for individuals at high risk for anemia and who have attained the age of six months but have not attained the age of 12 months.

- Fluoride varnish for prevention of tooth decay for minors at the age of eruption of their primary teeth.

- Fluoride supplements for prevention of tooth decay for minors six months of age or older who do not have fluoride in their water source.

- Gonorrhea prophylaxis treatment for newborns.

- Health history and physical exams for prenatal visits and for minors.

- Length and weight measurements for newborns and height and weight measurements for minors.

- Head circumference and weight-for-length measurements for newborns and minors who have not attained the age of three years.

- Body mass index for minors two years of age or older.

- Blood pressure measurements for minors three years of age or older and a blood pressure risk assessment at birth.

- Risk assessment and referral for oral health issues for minors who have attained the

age of six months but have not attained the age of seven years.

- Blood screening for newborns and minors who have not attained the age of two months.

- Screening for critical congenital health defects for newborns.

- Lead screenings.

- Metabolic and hemoglobin screening and screening for phenylketonuria, sickle cell anemia, and congenital hypothyroidism for minors including newborns.

- Tuberculin skin test based on risk assessment for minors one month of age or older.

- Tobacco counseling and cessation interventions for individuals who are five years of age or older.

- Vision and hearing screening and assessment for minors including newborns.

- Sexually transmitted infection and human immunodeficiency virus counseling for sexually active minors.

- Risk assessment for sexually transmitted infection for minors who are ten years of age or older and screening for sexually transmitted infection for minors who are 16 years of age or older.

- Alcohol misuse screening and counseling for minors 11 years of age or older.

- Autism screening for minors who have attained the age of 18 months but have not attained the age of 25 months.

- Developmental screening and surveillance for minors including newborns.

- Psychosocial and behavioral assessment for minors including newborns.

- Alcohol misuse screening and counseling for pregnant adults and a risk assessment for all adults.

- Fall prevention and counseling and preventive medication for fall prevention for community-dwelling adults 65 years of age or older.

- Screening and counseling for intimate partner violence for adult women.

- Well-woman visits for women who have attained the age of 18 years but have not attained the age of 65 years and well-woman visits for recommended preventive services, preconception care, and prenatal care.

- Counseling on, consultations with a trained provider on, and equipment rental for breastfeeding for pregnant and lactating women.

- Folic acid supplement for adult women with reproductive capacity.
- Iron deficiency anemia screening for pregnant and lactating women.
- Preeclampsia preventive medicine for pregnant adult women at high risk for preeclampsia.
- Low-dose aspirin after 12 weeks of gestation for pregnant women at high risk for miscarriage, preeclampsia, or clotting disorders.
- Screenings for hepatitis B and bacteriuria for pregnant women.
- Screening for gonorrhea for pregnant and sexually active females 24 years of age or younger and females older than 24 years of age who are at risk for infection.
- Screening for chlamydia for pregnant and sexually active females 24 years of age and younger and females older than 24 years of age who are at risk for infection.
- Screening for syphilis for pregnant women and adults who are at high risk for infection.
- Human immunodeficiency virus screening for adults who have attained the age of 15 years but have not attained the age of 66 years and individuals at high risk of infection who are younger than 15 years of age or older than 65 years of age.
- All contraceptives and services in accordance with separate statutory provisions.
- Any services not already specified having an A or B rating in current recommendations from the U.S. Preventive Services Task Force.
- Any preventive services not already specified that are recommended by the federal Health Resources and Services Administration's Bright Futures project.
- Any immunizations, not already specified under a separate statutory coverage mandate provision, that are recommended and determined to be for routine use by the federal Advisory Committee on Immunization Practices.

Prohibit insurance policies and government self-insured health plans, with certain exceptions, from subjecting the coverage of any of the listed preventive services to any deductible, copayments, or coinsurance under the policy or plan, and modify various statutory mandatory coverage provisions related to these preventive services to conform with this restriction.

Specify that the insurance policy or plan may apply deductibles to and impose copayments or coinsurance in the following circumstances: (a) if an office visit and a preventive service are billed separately by the health care provider, applicable only on the office visit but not on the preventive service; (b) if the primary reason for an office visit is not to obtain a preventive service, applicable on the office visit; or (c) if a preventive service is provided by a health care provider that is outside the policy's or plan's network of providers, unless the preventive service is provided by an out-of-network provider because there is no available health care provider in the policy's or

plan's network of providers that provides the preventive service. Specify that if multiple well-woman visits are required to fulfill all necessary preventive services and are in accordance with clinical recommendations, the insurance policy or health plan may not apply a deductible to or impose a copayment or coinsurance on any of those well-woman visits.

Other Insurance Mandatory Coverage Provisions. Modify a provision that requires health insurance plans and government self-insured plans to cover certain immunizations to add the following immunizations: (a) hepatitis A; (b) herpes zoster; (c) human papillomavirus; (d) meningococcal meningitis; (e) pneumococcal pneumonia; (f) influenza; and (g) rotavirus. Modify the immunization coverage mandate to extend the coverage requirement to any insured or plan participant, rather than just a child from birth to age six who is a child of the insured.

Modify a current law provision that requires health insurance policies and government self-insured plans to cover outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, if these services are covered for any other drug benefits under the policy or plan, to remove the clause that makes the coverage requirement contingent upon whether these services are coverage for any other drug benefits. Add to the coverage mandate sterilization procedures, and patient education and counseling for all females with reproductive capacity. Specify that an insurance policy or self-insured health plan may not may not apply a deductible or impose a copayment or coinsurance to at least one of each type of contraceptive method approved by the federal Food and Drug Administration for which coverage is required. Specify that the insurance policy or health plan may apply reasonable medical management to a method of contraception to limit coverage that is provided without being subject to a deductible, copayment, or coinsurance, to prescription drugs without a brand name. Authority the insurance policy or health plan to apply a deductible or impose a copayment or coinsurance for coverage of a contraceptive that is prescribed for a medical need if the services for the medical need would otherwise be subject to a deductible, copayment, or coinsurance.

Specify that these provisions first apply to policy or plan years beginning on January 1 of the year following the year of the first day of the fourth month beginning after the bill's general effective date, or, for policies and plans that are affected by a collective bargaining agreement containing provisions that are inconsistent with the bill, to policy or plan years beginning on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.

Some of the provisions contained in this item are intended to conform state laws with insurance market regulations contained in the federal Affordable Care Act (ACA). Since the ACA preempts state regulations with respect to many insurance market regulations, these provisions have no effect as long as the ACA is in effect in its present form. If the ACA's insurance market provisions were to not be in effect, the provisions in this item would maintain some of the ACA's market regulations for the individual and small group policies and for self-insured plans offered by a government entity. [The bill would not affect non-government self-insured plans since federal law preempts state law with respect to these benefit plans.] Specifically, the bill closely matches the ACA's regulations with respect to premium rating rules, guaranteed issue and renewal, prohibition against preexisting condition exclusions, non-discrimination in health care, the

essential health benefits, prohibition against lifetime or annual limits, and no cost-sharing for preventive services.

Some provisions in this item would affect provisions of state law that are not preempted by the ACA, and so would result in changes to insurance laws in the state. In particular, this item would require short-term, limited duration insurance policies to comply with the insurance market regulations that are generally applicable to other health benefit plans under the bill. The ACA does not regulate and does not preempt state law with respect to regulation of short-term plans and under current state law short-term plans are generally exempt from these market regulations.

Joint Finance/Legislature: Delete provision.